



GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH – HEALTH REGULATION AND LICENSING ADMINISTRATION

NEW LICENSE APPLICATION
PHARMACEUTICAL DETAILERS
BOARD OF PHARMACY

Please read instructions before completing this form. If you have any questions, call HRLA Customer Service at 1-877-672-2174, Monday through Friday, 8:00AM to 4:45PM EST. **A charge of \$65.00 will be imposed for dishonored checks (Public Law 89-208)**

SECTION 1. REQUESTED LICENSE TYPE/FEES (includes non-refundable application fee – see instructions)

☐ Pharmaceutical Detailer \$175.00

☐ Duplicate Licenses (limit 5) _____ X \$34.00 = \$ _____.00

Total Enclosed \$ _____.00

Make check or money order payable to
DC Treasurer.

MAIL TO:

Department of Health
Health Regulation and Licensing Administration
Board of Pharmacy
717 14th St NW, Suite 600
Washington, DC 20005

A decision will be made within sixty (60) days from receipt of the COMPLETED application and all supporting documents.

This license will expire at 12:00 Midnight, the last day of February of each even numbered year.

NOTE: Checks or money orders which are not made payable to "D.C. Treasurer" will be returned to you and your application processing will be delayed.

HRLA ONLY

Check \$	Check #	Staff
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\$ _____.00

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, please complete Section 4 on page 2. You must also provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

FIRST NAME MI LAST NAME SUFFIX
(Jr., Sr., etc.)

SOCIAL SECURITY NUMBER

If applicant does not have a social security number, a sworn affidavit is required.

MM DD YYYY

DATE OF BIRTH

PLACE OF BIRTH

Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female
GENDER
Please check the correct box.

SECTION 3. SUPPORTING DOCUMENTS REQUIRED

Please indicate the supporting documents you have included with this package or requested to be sent to the Board of Pharmacy. Keep a photocopy of all supporting documents for your records.

HRLA ONLY

A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"x2") with applicant's name printed on the back. <i>The photos must be original photos and cannot be computer-generated copies or paper copies.</i>	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
B.	One (1) clear photocopy of a U.S. government-issued photo ID.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Official certificate of graduation in a sealed envelope from the educational institution to the Board of Pharmacy (Board) with the completed application. To waive educational requirements, complete, sign and notarize the "Waiver of Educational Requirement" Form.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Completed, signed, and notarized "Affidavit to Abide by Code of Ethics" Form	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Check made payable to "D.C. Treasurer" in the amount of _____.	YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>

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Section 4. PREVIOUS NAMES

If your name has changed at any point since you first attended college or university, you must provide a copy of a legal name change document for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> FIRST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> MI	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> LAST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> SUFFIX
			(Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> FIRST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> MI	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> LAST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> SUFFIX
			(Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> FIRST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> MI	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> LAST NAME	<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> SUFFIX
			(Jr, Sr, etc.)

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

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			(Jr, Sr, etc.)

Section 5A. HOME ADDRESS

Even if you have a PO Box, a street address should also be provided, if applicable.

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> STATE		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> ZIP CODE + 4
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<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> HOME PHONE NUMBER		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> HOME FAX NUMBER
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Section 5B. BUSINESS ADDRESS

Please note: This information will be made available to the public.

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR ☐ PO BOX NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> STATE		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> ZIP CODE + 4
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<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> BUSINESS PHONE NUMBER		<div style="border-bottom: 1px solid black; height: 1.2em; width: 100%;"></div> BUSINESS FAX NUMBER
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Section 5C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed.

☐ HOME ☐ BUSINESS

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Section 6A. HIGHER EDUCATION SCHOOLS ATTENDED

List all schools that you have attended, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country	Number of Hours Completed	Date of Graduation	Type of Degree/Certificate

Section 6B. WORK EXPERIENCE

List all work experience since graduation from college, university and professional school, in reverse chronological order, beginning with the most recent.

Organization/Institution	Location	Start Date	End Date	Title/Position	Full Time	Part Time

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SECTION 7. QUESTIONS – Applicants MUST answer all of the following questions.

Please answer all of the following questions by placing an "X" in the appropriate boxes. If you answer "Yes" to questions B through H below, you must provide full information and complete details on a separate sheet of paper, including copies of relevant documents, and attach it to this application.

**HRLA
ONLY**

A. Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License** for which you are now applying, and fine you one thousand dollars (\$1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

As of this date, do you owe more than one hundred dollars (\$100.00) to the District of Columbia Government as a result of any of the following:

Yes No
☐ ☐

YES NO
☐ ☐

1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985);
2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994);
3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985);
4. Past due taxes;
5. Past due District of Columbia Water and Sewer Authority service fees; or

B.	Have you ever been arrested for or convicted of a crime or misdemeanor (other than minor traffic violations)?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
C.	Do you have a physical, medical or mental condition that currently impairs your ability to practice your profession?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
D.	Have you ever been diagnosed or treated for substance abuse or is your ability to practice your profession impaired by alcohol or drug use?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
E.	Has any authority, peer review board, or professional association taken adverse action against you?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
F.	Are you currently under investigation or were you investigated by any authority, peer review board, or professional association for any violation of state, federal, or local law?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
G.	Has any authority or peer review board informed you of any pending charges(s) or investigation?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>
H.	Have you ever been terminated or asked to resign from a pharmaceutical detailer position?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	<input type="checkbox"/>

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE

NAME (Please Print)

DATE

**HRLA
ONLY**

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To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.